FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016618

Facility Name: Mid America Care Center

Address: 4920 N. Kenmore Ave (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 769-2700 **Fax #** (773) 769-3226

IDPA ID Number: 362688753001

Date of Initial License for Current Owners: 00/00/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds None

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	310	Skilled (SNF)	310	113,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	310	TOTALS	310	113,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	57,384		3,004	60,388	8
9	SNF/PED					9
10	ICF	27,380	1,066		28,446	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	84,764	1,066	3,004	88,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.30%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 2,866

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	323,739	89,788	16,333	429,860		429,860		429,860			1
2	Food Purchase		387,395		387,395	(39,967)	347,428	(2,241)	345,186			2
3	Housekeeping	295,958	91,105		387,063		387,063	1,441	388,504			3
4	Laundry	140,529	16,910		157,439		157,439		157,439			4
5	Heat and Other Utilities			197,984	197,984		197,984	5,210	203,194			5
6	Maintenance	176,333	39,606	68,641	284,580		284,580	(13,378)	271,202			6
7	Other (specify):*							40	40			7
8	**TOTAL General Services**	936,559	624,804	282,958	1,844,321	(39,967)	1,804,354	(8,928)	1,795,425			8
	B. Health Care and Programs											
9	Medical Director			9,350	9,350		9,350		9,350			9
10	Nursing and Medical Records	2,557,901	106,989	272,037	2,936,927		2,936,927		2,936,927			10
10a	Therapy	239,671		18,116	257,787		257,787		257,787			10a
11	Activities	175,116	19,289	1,105	195,510		195,510		195,510			11
12	Social Services	168,478		448	168,926		168,926		168,926			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,141,166	126,278	301,056	3,568,500		3,568,500		3,568,500			16
	C. General Administration											
17	Administrative	244,383		90,000	334,383		334,383	56,919	391,302			17
18	Directors Fees											18
19	Professional Services			488,121	488,121	(8,408)	479,713	(437,872)	41,841			19
20	Dues, Fees, Subscriptions & Promotions			89,016	89,016		89,016	(63,236)	25,780			20
21	Clerical & General Office Expenses	159,010	47,043	72,849	278,902		278,902	102,757	381,659			21
22	Employee Benefits & Payroll Taxes			832,736	832,736	39,967	872,703		872,703			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,752	3,752		3,752	1,225	4,977			24
25	Other Admin. Staff Transportation			1,545	1,545		1,545	146	1,691			25
26	Insurance-Prop.Liab.Malpractice			367,414	367,414		367,414	1,812	369,226			26
27	Other (specify):*							68,038	68,038			27
28	**TOTAL General Administration**	403,393	47,043	1,945,433	2,395,869	31,559	2,427,428	(270,211)	2,157,217			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,481,118	798,125	2,529,447	7,808,690	(8,408)	7,800,282	(279,139)	7,521,143			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mid America Care Center #0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			181,022	181,022		181,022	(28,581)	152,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,869	87,869		87,869	(43,814)	44,055			32
33	Real Estate Taxes			326,307	326,307	8,408	334,715	(1,778)	332,937			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,786	9,786		9,786	291	10,077			35
36	Other (specify):*											36
37	**TOTAL Ownership**			604,984	604,984	8,408	613,392	(73,882)	539,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,746	254,262	355,008		355,008		355,008			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			170,190	170,190		170,190		170,190			42
43	Other (specify):*	142,590			142,590		142,590	(142,590)	0			43
44	**TOTAL Special Cost Centers**	142,590	100,746	424,452	667,788		667,788	(142,590)	525,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,623,708	898,871	3,558,883	9,081,462		9,081,462	(495,611)	8,585,851			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,030)	30		9
10	Interest and Other Investment Income	(49,489)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(14,392)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,727)	21		24
25	Fund Raising, Advertising and Promotional	(47,493)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(224,342)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (406,519)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(89,092)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (89,092)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (495,611)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Mid America Care Center

ID# 0016618

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (9,545)	06	1
2	Non-Allowable Legal Fees	(200)	19	2
3	COPE	(2,468)	20	3
4	Vending Income	(2,195)	02	4
5	Rental Income	(15,450)	06	5
6	Jury Duty Income	(103)	21	6
7	Building 4930 Repairs & Maintenance	(1,276)	06	7
8	Marketing Salaries	(142,590)	43	8
9	Franchise Tax	(150)	21	9
10	Theft & Loss	(686)	21	10
11	Replacement Tax	(218)	21	11
12	Building 4930 Real Estate Tax	(5,605)	33	12
13	Building 4930 Depreciation	(7,952)	30	13
14	Misc. Income	(103)	21	14
15	Non-Allowable Wages	(35,801)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
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96				96
97				97
98				98
99				99
100				100
101	Total	(224,342)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,241)											(2,241)	2
3	Housekeeping				1,441								1,441	3
4	Laundry													4
5	Heat and Other Utilities				2,321	2,889							5,210	5
6	Maintenance	(26,271)			10,623	2,270							(13,378)	6
7	Other (specify):*					40							40	7
8	**TOTAL General Services**	(28,512)			14,385	5,199							(8,928)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(55,197)	111,019	1,097							56,919	17
18	Directors Fees													18
19	Professional Services	(200)		693	(438,602)	237							(437,872)	19
20	Fees, Subscriptions & Promotions	(64,353)		102	1,002	13							(63,236)	20
21	Clerical & General Office Expenses	(66,788)		206	168,925	414							102,757	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				1,225								1,225	24
25	Other Admin. Staff Transportation				146								146	25
26	Insurance-Prop.Liab.Malpractice				1,523	289							1,812	26
27	Other (specify):*			2,720	65,318								68,038	27
28	**TOTAL General Administration**	(131,341)		(51,476)	(89,444)	2,050							(270,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(159,853)		(51,476)	(75,059)	7,249							(279,139)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mid America Care Center # 0016618 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(48,982)		219	18,068	2,114							(28,581)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(49,489)			872	4,803							(43,814)	32
33	Real Estate Taxes	(5,605)				3,827							(1,778)	33
34	Rent-Facility & Grounds				21,012	(21,012)								34
35	Rent-Equipment & Vehicles				291								291	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(104,076)		219	40,243	(10,268)							(73,882)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(142,590)											(142,590)	43
44	**TOTAL Special Cost Centers**	(142,590)											(142,590)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(406,519)		(51,257)	(34,816)	(3,019)							(495,611)	45

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 34,803	$ 34,803	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	693	693	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	102	102	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	206	206	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	2,720	2,720	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	219	219	20
21	V								21
22	V	17	MANAGEMENT FEES	90,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(90,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,000			$ 38,743	$ * (51,257)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 1,441	$ 1,441	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,321	2,321	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	10,623	10,623	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	111,019	111,019	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	358	358	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	1,002	1,002	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	168,925	168,925	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	1,225	1,225	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	146	146	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	1,523	1,523	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	65,318	65,318	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	18,068	18,068	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	872	872	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	21,012	21,012	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	291	291	30
31	V	19	HOME OFFICE	438,960	MANAGCARE, INC.	100.00%		(438,960)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 438,960			$ 404,144	$ * (34,816)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 2,889	$ 2,889	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		2,270	2,270	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		40	40	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		1,097	1,097	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		237	237	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		13	13	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		414	414	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		289	289	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		2,114	2,114	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		4,803	4,803	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		3,827	3,827	25
26	V	34	RENT	21,012	MAZEL MANAGEMENT			(21,012)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,012			$ 17,993	$ * (3,019)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Davis	Shareholder	Relative	54.08%	See Attached	23.76	39.60%	Intercare,Sal	$ 49,803	17-1,17-7	1
2	Moshe Davis	Operations Dir	Administrative	0.53%	See Attached	11.50	19.17%	Salary	28,782	17-1	2
3	Yehoshua Davis	Director	Administrative	0.53%	See Attached	39.00	65.00%	Salary	115,130	17-1	3
4	Shoshana Braun	Clinical Support	Nursing Clerical	0.53%	See Attached	12.00	30.00%	Salary	8,942	10-1	4
5	Chasida Davis	Bookkeeper	Clerical	0%	See Attached	16.38	40.95%	Managcare	15,762	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 218,419		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	7	$ 87,900	$ 87,900	24	$ 34,803	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	7	1,750		24	693	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	7	257		24	102	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	7	521		24	206	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	7	6,869		24	2,720	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	7	552		24	219	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 97,849	$ 87,900		$ 38,743	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	216,882	5	$ 3,519	$	88,834	$ 1,441	1
2	5	UTILITIES	PATIENT DAYS	216,882	5	5,668		88,834	2,321	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	216,882	5	25,935		88,834	10,623	3
4	10	NURSING SALARIES	PATIENT DAYS	216,882	5			88,834		4
5	17	ADMINISTRATIVE	PATIENT DAYS	216,882	5	271,046	271,046	88,834	111,019	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	216,882	5	875		88,834	358	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	216,882	5	2,447		88,834	1,002	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	216,882	5	412,419	353,888	88,834	168,925	8
9	24	SEMINARS	PATIENT DAYS	216,882	5	2,990		88,834	1,225	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	216,882	5	357		88,834	146	10
11	26	INSURANCE	PATIENT DAYS	216,882	5	3,719		88,834	1,523	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	216,882	5	159,470		88,834	65,318	12
13	30	DEPRECIATION	PATIENT DAYS	216,882	5	44,112		88,834	18,068	13
14	32	INTEREST EXPENSE	PATIENT DAYS	216,882	5	2,130		88,834	872	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	216,882	5	51,300		88,834	21,012	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	216,882	5	711		88,834	291	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 986,698	$ 624,934		$ 404,144	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	216,882	5	$ 7,053	$	88,834	$ 2,889	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	216,882	5	5,541		88,834	2,270	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	216,882	5	96		88,834	40	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	216,882	5	2,679		88,834	1,097	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	216,882	5	580		88,834	237	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	216,882	5	31		88,834	13	6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	216,882	5	1,012		88,834	414	7
8	26	INSURANCE	MNGCR. PATIENT DAYS	216,882	5	706		88,834	289	8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	216,882	5	5,162		88,834	2,114	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	216,882	5	11,726		88,834	4,803	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	216,882	5	9,342		88,834	3,827	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 43,928	$		$ 17,993	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB Financial		X				$	$ 275,000			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line Of Credit				3,000,000			71,922	6
7	MB Financial		X	Line Of Credit				150,000			15,947	7
8	See Supplemental Schedule							16,141			5,675	8
9	TOTAL Facility Related						$	$ 3,441,141			$ 93,544	9
	B. Non-Facility Related*											
10	Interest Income		X								(49,489)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (49,489)	14
15	TOTALS (line 9+line14)						$	$ 3,441,141			$ 44,055	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Automobile Loan		X				$	$ 16,141			$	8
9	Allocated From Managcare	X									872	9
10	Allocated From Mazel Mgmt	X									4,803	10
11												11
12												12
13												13
14	TOTAL Working Capital							16,141			5,675	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 390,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 351,953	2
3. Under or (over) accrual (line 2 minus line 1).		$ (38,047)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 362,575	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 8,408	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 332,936	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	373,617	8
	2000	368,742	9
	2001	378,332	10
	2002	378,498	11
	2003	348,126	12

2004 Accrual: $353,731.9 x 1.025 = $362575.2

Allocated From Mazel Management = $3,835.96

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-017-0000	4930 N. Kenmore	$ 5,605.46	$
2.	14-08-410-018-0000	4928 N. Kenmore	$ 96,551.55	$ 96,551.55
3.	14-08-410-019-0000	4922 N. Kenmore	$ 96,551.55	$ 96,551.55
4.	14-08-410-020-0000	4918 N. Kenmore	$ 96,551.55	$ 96,551.55
5.	14-08-410-021-0000	4912 N. Kenmore	$ 58,471.79	$ 58,471.79
6.	Allocated From Mazel Mgmt		$ 40,849.28	$ 3,835.96
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 394,581.18	$ 351,962.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,500 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,500	1979	$ 307,874	1
2					2
3	TOTALS	94,500		$ 307,874	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	2,575		20	-		2,575	9
10	Various			1979	33,995		20	-		33,995	10
11	Various			1980	13,673		20	-		13,673	11
12	Various			1981	107,932		20	4,205	(4,205)	103,033	12
13	Various			1982	4,750		20	-		4,750	13
14	Various			1983	1,787		20	-		1,787	14
15	Various			1984	25,291		20	202	202	25,042	15
16	Various			1985	17,828		20	76	76	17,648	16
17	Various			1986	62,698		20	1,033	1,033	60,688	17
18	Various			1987	18,422		20	501	501	15,023	18
19	Various			1988	33,825		20	1,353	1,353	22,626	19
20	Various			1989	23,916		20	1,029	1,029	20,370	20
21	Various			1990	23,550		20	1,178	1,178	17,092	21
22	Various			1991	20,020		20	429	429	9,034	22
23	Various			1992	51,260		20	2,563	2,563	31,781	23
24	Various			1993	7,134		20	357	357	4,351	24
25	Various			1994	32,273		20	1,613	1,613	16,565	25
26	Various			1995	227,831		20	11,547	11,547	109,776	26
27	Various			1996	136,732		20	6,837	6,837	58,603	27
28	Various			1997	26,804		20	1,340	1,340	10,104	28
29	Various			1998	81,506		20	4,077	4,077	26,310	29
30	Various			1999	113,499		20	5,676	5,676	31,357	30
31	Various			2000	308,605		20	15,599	15,599	70,227	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,258,613					3,258,613	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		108,735	4,900		4,699	(201)	81,866	68
69	Financial Statement Depreciation			113,711			(113,711)		69
70	TOTAL (lines 4 thru 69)		$ 4,743,254	$ 118,611		$ 64,314	$ (62,707)	$ 4,046,889	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,743,254	$ 118,611		$ 64,314	$ (54,297)	$ 4,046,889	1
2	Lock System	2001	2,862		20	143	143	560	2
3	Doors & Locks	2001	6,519		20	326	326	1,277	3
4	Monitor	2001	1,875		20	94	94	352	4
5	Monitor	2001	4,021		20	201	201	720	5
6	Humiguard & Tile	2001	1,814		20	91	91	310	6
7	Monitor	2001	1,931		20	97	97	330	7
8	Monitor	2001	1,206		20	60	60	201	8
9	Monitor	2001	1,695		20	85	85	282	9
10	Masonary Work	2001	2,600		20	130	130	423	10
11	Transmitter	2001	1,073		20	54	54	175	11
12	Wall Repair	2001	6,800		20	340	340	1,077	12
13	Door Operator	2001	4,606		20	230	230	902	13
14	Steel Selector Tape	2001	2,113		20	106	106	344	14
15	Roof Repair	2001	2,750		20	138	138	436	15
16	Elec. Cir. & Outlet	2001	2,845		20	142	142	439	16
17	Patio Area Fence	2001	1,784		20	89	89	290	17
18	Motors	2001	549		20	27	27	87	18
19	Turbine Pump	2001	2,943		20	147	147	576	19
20	Alarm/Transmitter	2001	1,244		20	62	62	192	20
21	Fire Alarm System	2001	1,091		20	55	55	187	21
22	Asphalt Repair	2001	2,740		20	137	137	491	22
23	Paint	2001	1,456		20	73	73	285	23
24	Install Ceramic Tile	2002	4,000		20	400	400	1,167	24
25	Flooring	2002	1,818		20	182	182	545	25
26	Carpentry Work	2002	2,700		20	270	270	765	26
27	Flooring	2002	1,407		20	141	141	410	27
28	Carpentry Work	2002	4,420		20	442	442	1,142	28
29	Flooring	2002	1,786		20	179	179	506	29
30	Carpentry	2002	9,318		20	932	932	2,562	30
31	Carpentry	2002	2,620		20	262	262	721	31
32	Floor Tile	2002	5,809		20	581	581	1,597	32
33	Monitoring Cameras	2002	1,556		20	311	311	804	33
34	TOTAL (lines 1 thru 33)		$ 4,835,205	$ 118,611		$ 70,841	$ (47,770)	$ 4,067,044	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,835,205	$ 118,611		$ 70,841	$ (47,770)	$ 4,067,044	1
2	A/C	2002	9,960		20	1,992	1,992	5,478	2
3	A/C Circuits	2002	3,686		20	737	737	1,782	3
4	Doors	2002	613		20	61	61	128	4
5	Doors	2002	613		20	61	61	133	5
6	Elevator	2002	4,180		20	209	209	435	6
7	Fence	2002	2,207		20	147	147	392	7
8	Fence Installation	2002	2,207		20	110	110	303	8
9	Electrical	2002	1,173		20	59	59	152	9
10	Fan Blade	2002	1,824		20	91	91	213	10
11	Door Transmitter	2002	2,180		20	109	109	245	11
12	Door Screens	2002	1,210		20	61	61	136	12
13	Elevator Repairs	2002	1,540		20	77	77	186	13
14	Control Panel	2003	2,810		20	281	281	562	14
15	Annuciator Panel	2003	3,105		20	311	311	492	15
16	Elevator Key Pad	2003	1,092		20	55	55	109	16
17	Water Heater	2003	6,650		20	554	554	1,062	17
18	Smoke Dampers	2003	2,380		20	238	238	436	18
19	Air Handler	2003	3,975		20	398	398	431	19
20	Fire Alarm	2003	4,081		20	408	408	442	20
21	Elevator Flooring	2003	1,185		20	59	59	114	21
22	Fire Alarm Duct	2003	930		20	47	47	93	22
23	Fire Alarm Repair	2003	618		20	31	31	59	23
24	Air Filter Motor	2003	1,403		20	70	70	134	24
25	Door Locking System	2003	699		20	35	35	67	25
26	Fire Dampers	2003	1,016		20	51	51	97	26
27	Smoke Dampers	2003	519		20	26	26	52	27
28	Evaporator Fan Motor	2003	591		20	30	30	47	28
29	Latching Alarm System	2003	697		20	35	35	52	29
30	Alarm Bell	2003	602		20	30	30	40	30
31	Fire Alarm Repair	2003	720		20	36	36	39	31
32	Awning	2004	2,307		20	19	19	19	32
33	Carpeting	2004	1,357		20	32	32	32	33
34	TOTAL (lines 1 thru 33)		$ 4,903,335	$ 118,611		$ 77,301	$ (41,310)	$ 4,081,006	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,903,335	$ 118,611		$ 77,301	$ (41,310)	$ 4,081,006	1
2	Digital Keypad	2004	1,379		20	23	23	23	2
3	Walk In Freezer Repair	2004	615		20	5	5	5	3
4	Nurses Station Electrical	2004	1,302		20	16	16	16	4
5	Door Locking System Repair	2004	847		20	18	18	18	5
6	Exterior Door Repair	2004	543		20	11	11	11	6
7	Door Locking System Repair	2004	757		20	22	22	22	7
8	Generator Maintenance	2004	850		20	21	21	21	8
9	Chiller System Repair	2004	565		20	14	14	14	9
10	Elevator Repair	2004	529		20	15	15	15	10
11	Elevator Repair	2004	545		20	18	18	18	11
12	Monitoring System Repair	2004	1,141		20	48	48	48	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,912,406	$ 118,611		$ 77,512	$ (41,099)	$ 4,081,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1971	$ 3,258,613	$		$	$	$ 3,258,613	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,258,613	$		$	$	$ 3,258,613	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From Mazel Management		1985	1985	$ 42,257	$ 1,698	30	$ 1,409	$ (289)	$ 27,115	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Managcare			1997	4,926	219	20	493	274	3,654	9
10	Allocated From Managcare			1993	386	-	20	19	19	223	10
11	Allocated From Managcare			1988	603	19	20	30	11	489	11
12	Allocated From Managcare			1986	45,700	2,334	20	2,093	241	42,217	12
13											13
14	Allocated From Mazel Management			2001	887	23	20	44	21	155	14
15	Allocated From Mazel Management			2000	448	11	20	22	11	96	15
16	Allocated From Mazel Management			1998	1,581	54	20	79	25	530	16
17	Allocated From Mazel Management			1997	1,474	38	20	74	36	541	17
18	Allocated From Mazel Management			1996	1,005	11	20	50	39	431	18
19	Allocated From Mazel Management			1995	227	6	20	11	5	109	19
20	Allocated From Mazel Management			1994	897	17	20	45	28	424	20
21	Allocated From Mazel Management			1993	530	15	20	26	11	303	21
22	Allocated From Mazel Management			1991	397	13	20	19	6	252	22
23	Allocated From Mazel Management			1990	617	13	20	31	18	443	23
24	Allocated From Mazel Management			1989	386	9	20	16	7	252	24
25	Allocated From Mazel Management			1987	877	17	20	-	(17)	877	25
26	Allocated From Mazel Management			1986	3,542	184	20	150	(34)	3,304	26
27	Allocated From Mazel Management			1985	247	-	20	-		247	27
28											28
29	Allocated From Intercare, Ltd.			2001	1,748	219	20	88	(131)	204	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 108,735	$ 4,900		$ 4,699	$ 281	$ 81,866	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 491,391	$ 61,051	$ 49,424	$ (11,627)	10	$ 297,597	71
72	Current Year Purchases	203,591	425	6,378	5,953	10	6,378	72
73	Fully Depreciated Assets	701,407				10	701,317	73
74								74
75	TOTALS	$ 1,396,389	$ 61,476	$ 55,802	$ (5,674)		$ 1,005,292	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		AUTOMOBILE	1983	$	$	$	$		$	76
77		1994 ALTIMA	1994							77
78		MITSUBISHI	2003	22,522		5,743	5,743	5	9,122	78
79		Allocated From Managcare	2004	81,682	13,384	13,384		5		79
80	TOTALS			$ 104,204	$ 13,384	$ 19,127	$ 5,743		$ 9,122	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,720,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,471	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,441	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,030)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,095,631	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1994 ALTIMA - 1994	$ 17,799	$	$	86
87	4930 BLDG - 1998	159,035	7,952	54,338	87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	$ 194,334	$ 7,952	$ 54,338	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 291 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2002 Lexus	$ 569.70	$ 6,836	17
18	Facility	1999 Dodge Caravan	245.81	2,950	18
19					19
20					20
21	TOTAL		$ 815.51	$ 9,786	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 57,423	$		$ 57,423	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,151			13,151	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,001			1,001	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			176,286			176,286	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 03				3,510	19,665		23,175	12
13	Other (specify): See Supplemental					2,891	81,081		83,972	13
14	TOTAL			$		$ 254,262	$ 100,746		$ 355,008	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 113,040	$	1
2	Cash-Patient Deposits	6,813		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,385,630		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	337,849		6
7	Other Prepaid Expenses	8,566		7
8	Accounts Receivable (owners or related parties)	2,381,754		8
9	Other(specify): See Attached Schedule	144,407		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,378,059	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	325,374		13
14	Buildings, at Historical Cost	3,417,648		14
15	Leasehold Improvements, at Historical Cost	1,475,737		15
16	Equipment, at Historical Cost	1,279,457		16
17	Accumulated Depreciation (book methods)	(5,190,874)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	5,675		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,313,017	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,691,076	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 922,258	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	111,130		28
29	Short-Term Notes Payable	166,141		29
30	Accrued Salaries Payable	173,609		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,498		31
32	Accrued Real Estate Taxes(Sch.IX-B)	362,575		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	25,003		35
	Other Current Liabilities(specify):			
36	See Attached Schedule	8,995		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,787,209	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,275,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,275,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,062,209	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,628,867	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,691,076	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,207,104	1
2	Restatements (describe):		2
3	**Depreciation Expense**	(9,829)	3
4	**State Replacement Tax**	(7,600)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,189,675	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	439,192	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 439,192	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,628,867	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,386,964	1
2	Discounts and Allowances for all Levels	(384,404)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,002,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,726	6
7	Oxygen	837	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,563	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	116,952	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,182	19
20	Radiology and X-Ray	1,370	20
21	Other Medical Services	57,790	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 185,294	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,489	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,489	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17,748	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,748	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,520,654	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,844,321	31
32	Health Care	3,568,500	32
33	General Administration	2,395,869	33
	B. Capital Expense		
34	Ownership	604,984	34
	C. Ancillary Expense		
35	Special Cost Centers	497,598	35
36	Provider Participation Fee	170,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,081,462	40
41	**Income before Income Taxes (line 30 minus line 40)****	439,192	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 439,192	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,056	$ 67,214	$ 32.69	1
2	Assistant Director of Nursing	2,764	3,122	78,246	25.06	2
3	Registered Nurses	25,216	26,732	612,036	22.90	3
4	Licensed Practical Nurses	21,798	23,597	422,269	17.90	4
5	Nurse Aides & Orderlies	130,246	139,920	1,322,720	9.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,671	18,338	239,671	13.07	8
9	Activity Director	2,016	2,240	43,661	19.49	9
10	Activity Assistants	15,030	16,294	131,455	8.07	10
11	Social Service Workers	12,009	12,993	168,478	12.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,861	33,648	323,739	9.62	15
16	Dishwashers					16
17	Maintenance Workers	13,458	14,601	176,333	12.08	17
18	Housekeepers	35,388	38,057	295,958	7.78	18
19	Laundry	15,486	17,096	140,529	8.22	19
20	Administrator	1,683	1,850	115,130	62.23	20
21	Assistant Administrator	2,255	2,506	85,471	34.11	21
22	Other Administrative	1,716	1,751	43,782	25.00	22
23	Office Manager					23
24	Clerical	13,820	14,979	159,010	10.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,990	4,254	55,416	13.03	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,191	4,191	142,590	34.02	33
34	TOTAL (lines 1 - 33)	350,510	378,225	$ 4,623,708 *	$ 12.22	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	375	$ 16,333	01-03	35
36	Medical Director	Monthly	9,350	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	3,511	140,439	10-03	38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant	166	8,687	10a-03	40
41	Occupational Therapy Consultant	146	7,600	10a-03	41
42	Respiratory Therapy Consultant	8	279	10a-03	42
43	Speech Therapy Consultant	30	1,550	10a-03	43
44	Activity Consultant	21	1,105	11-03	44
45	Social Service Consultant	8	448	12-03	45
46	Other(specify) Quality Assurance	Monthly	1,000	10-03	46
47	Program Development Consultant	Monthly	27,000	10-03	47
48	Renal Therpary Consultant	299	14,934	10-03	48
49	TOTAL (lines 35 - 48)	4,563	$ 234,653		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,443	82,736	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,443	$ 82,736		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehoshua Davis	Administrator	.53%	$ 115,130
Michael Applebaum	Assistant Admin	0%	80,272
Linda Weiss	Assistant Admin	0%	5,198
Yosef Davis	Director	54.08%	15,000
Moshe Davis	Director	.53%	28,782
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 244,382

B. Administrative - Other

Description	Amount
Management Fees - Intercare	$ 90,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 90,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Myers, Miller & Krauskopf	Legal Fees	$ 883
Ungaretti & Harris	Legal Fees	4,831
Rieff Schramm & Kanter	Legal Fees	8,408
Winston & Strawn	Legal Fees	3,070
CT Corporation	Legal Fees	200
Econocare	Purchasing Consultant	5,220
Managcare Fees	Bookkeeping	438,960
Frost, Ruttenberg & Rothblatt	Accounting Fees	21,560
FRS Healthcare	PMA Audit Fees	3,000
Personnel Planners	Unemployment Consult.	1,990
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 488,121

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,654
Unemployment Compensation Insurance	43,382
FICA Taxes	353,597
Employee Health Insurance	233,987
Employee Meals	39,967
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	4,853
Chicago Head Tax	9,155
Disability Insurance	5,437
Employee Pension	58,331
Employee Benefits	43,339
TOTAL (agree to Schedule V, line 22, col.8)	$ 872,701

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,132
Health Care Worker Background Check	
(Indicate # of checks performed 41)	1,003
Licenses & Permits	3,034
ILCLTC	14,318
IL Assoc. Of Health Care Facilities	1,550
Dues & Subscriptions	1,625
Allocated From Managcare	1,002
See Supplemental Schedule	115
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,779

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,752
Allocated From Managcare	1,225
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 4,977

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center **#** 0016618 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $16,786.52**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **No**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,965** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **170,190**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **39,967** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.